SECTION 2

UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES FOR INDIVIDUALS 65 AND OVER PROVIDER MANUAL

Table of Contents

1 GENERAL POLICY

Under section 1915© of the Social Security Act, a State may request approval through the federal Health Care Financing Administration (HCFA) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The state of Utah has provided Medicaid reimbursed home and community-based waiver services for elderly individuals 65 and older since July 1, 1992. On July 30, 1995 the Division of Health Care Financing received approval from HCFA to expand the array of waiver benefits and to extend the waiver's effective date through June 30, 2000. The approval includes waivers of:

* the "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act, and

* the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide the services described in Chapter 3, *Home and Community-Based Waiver Services,* of this manual to *only a limited number* of eligible individuals who meet the State's criteria for Medicaid reimbursement in a nursing facility (NF). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-effective" or a "cost-neutral" alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements the State uses more liberal eligibility and post-eligibility income and resource calculations when determining recipients' Medicaid eligibility. For example, recipients are permitted to retain more of their monthly income than NF recipients in order to compensate for the higher costs associated with living in the community.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for elderly individuals 65 or older, the following acronyms and definitions apply:

AAA Area Agency on Aging

DAAS Division of Aging and Adult Services

DHCF Division of Health Care Financing

HCFA Health Care Financing Administration

HCBS Home and Community-Based Services

Homebound Homebound means individuals unable to leave the confines of their homes without assistance.

NF Nursing facility

1 - 2 Qualified Providers

Home and community-based waiver services for recipients who are 65 or older are covered benefits only when delivered by or through the local Area Agency on Aging (AAA) or local case management agency that is enrolled with the Medicaid agency to provide such services. All providers of waiver services must have a current contract with the local case management agency for the provision of waiver services.

A. Case Management Services

Qualified case managers must:

1. be licensed registered nurses or licensed social service workers, practicing within the scope of their license in accordance with Title 58 of Utah Code Annotated, 1953 as amended. The social service worker is the primary case manager with the registered nurse acting as a consultant;

   (Exception to SSW licensure may be granted if a request is made in writing to the Division of Aging and Adult Services.)

2. be trained in the Utah Department of Health Resident Assessment long-term care level-of-care determination criteria; and have one year of experience working with a geriatric population;

3. employed by or under contract with a case management agency.

B. Adult Day Care

Providers of adult day care must be licensed by the Department of Human Services to operate as an adult day care center.

C. In-Home Respite Care

Providers of respite care must:

1. be licensed by the Department of Health to operate as a home health agency; or

2. be authorized by the local AAA as a Senior Volunteers Program to provide respite care to adults;

D. Overnight Respite Care

Providers of overnight respite care must be a Medicaid-certified nursing facility, swing-bed hospital, assisted living facility, adult day care centers, or residential care facility that meets State standards.

E. Homemaker Services

Providers of homemaker services must:

1. be licensed by the Department of Health to operate as a home health agency; or

2. be a homemaker agency with a current city license, adequate bonding, and appropriate training for homemakers.

F. Supportive Maintenance Services

Providers of supportive maintenance must be licensed by the Department of Health to operate as a home health agency.

G. Non-Medical Transportation

Providers of transportation must:

1. have certification issued by the Division of Aging and Adult Services; or

2. have a business license to engage in the transporting of passengers.

H. Emergency Response System

Providers of emergency response systems services must be licensed by the Federal Communications Commission as an alarm system network; or be credentialed according to the laws governing emergency response systems in the state where an agency is headquartered.

I. Home-Delivered Meals

A provider of home-delivered meals must be certified by the Division of Aging and Adult Services to provide meals.

J. Companion Services

Providers of companion services must be authorized by the local AAA as a Senior Volunteers Program to provide companion services to adults.

1 - 3 Service Standards

In addition to service standards and limitations described in this manual, home and community-based waiver providers will be held accountable to the standards and policies contained in:

A. the provider contracts with the local Area Agency on Aging or other case management agencies.

B. the Medicaid *Provider Agreement for Title XIX Home and Community-Based Services Waiver* filed with the Utah Department of Health, Division of Health Care Financing.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided:

1. to an eligible recipient residing in the community in Utah;

2. pursuant to a written plan of care.

2 - 1 Eligibility for Waiver Program

A. Home and community-based waiver services are covered benefits only *for a limited number of Medicaid eligibles* who, but for the provision of such services, would require the level of care provided in a Medicaid-certified NF, the cost of which would be reimbursed under the Medicaid State Plan.

B. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, the level-of-care R.N. shall document that at least two of the following factors exist:

1. As a result of a diagnosed medical condition, the individual requires substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

2. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or

3. The medical condition and intensity of services indicate that the care needs of the individual cannot be met safely in a less structured setting than is provided by the waiver and alternatives have been explored and are not feasible.

C. An individual will <u>not</u> be offered waiver services if the assessment indicates he or she cannot safely be maintained in the community.

D. Once determined eligible, each individual must be offered an informed choice of receiving either NF or waiver services.

E. Inpatients of hospitals, nursing facilities, or ICFs/MR are not eligible to receive waiver services (except as specifically permitted for case management discharge planning in the 30-day period before their discharge to the HCBS waiver).

2 - 2 Assessment

The local case management agency is the only enrolled provider of waiver case management services for the area served by the agency and is the first point of contact for access to waiver services. Prior to admitting an individual to the waiver, a qualified waiver case manager must:

A. perform the initial evaluation of level of care within 14 days after a request for such evaluation. The request for waiver assessment may be made by the individual or legal representative, or referral by other competent authority (such as doctor, discharge planning team, social worker, etc.)

B. assess the individual's needs and condition;

C. determine whether the individual qualifies for Medicaid-reimbursed NF care and services;

D. determine whether feasible alternatives are available in the community, including waiver services;

E. verify the individual's Medicaid eligibility or arrange for Medicaid eligibility determination;

F. offer the eligible applicant an informed choice of waiver services or NF services; and

G. certify on the approved consent form that the individual meets the criteria for and chooses to receive waiver services;

2 - 3 Level-of-Care Evaluation/Determination

A. Level-of-care evaluations (and periodic reevaluations) are conducted by the waiver case management team.

B. Either the registered nurse employed by or under contract by the case management agency (trained in Utah Department of Health Resident Assessment Long-Term Care Level-of-Care determination criteria) or the registered nurse employed by the Division of Aging and Adult Services may certify that an individual meets the home and community-based waiver level-of-care criteria.

2 - 4 Recipient Freedom of Choice

A. When an applicant is initially determined eligible for waiver services, the applicant or legal representative will be informed of the alternatives available under the waiver. If there is a waiting list for admission to the waiver, the waiver case manager will inform the applicant about the waiting list procedures and selection criteria. (Refer to Chapter 2 - 5, *Waiting List*)

B. Once informed of the feasible alternatives under the waiver, the eligible individual or legal representative will be offered the choice of institutional (NF) or home and community-based services. The individual's choice is documented on the Consent Form.

C. If waiver services are chosen, the applicant or legal representative will also be given the opportunity to choose the providers of waivered services if more than one qualified provider is available. The applicant's choice of services and providers is documented in the plan of care.

D. Once the applicant has chosen home and community-based waiver services and the choice has been documented by the waiver case manager, annual redocumentation of choice is not required. However, a recipient has the option to choose institutional (NF) care at any time he or she is receiving waiver services.

2 - 5 Waiting List

The State may serve only a limited number of recipients during each waiver year. For purposes of this waiver, a “waiver year” is July 1 through June 30 of the following year.

When the number of recipients served during the waiver year reaches the number approved by HCFA, a waiting list will be established. When vacancies occur, the waiver case manager will select the individuals on the waiting list most in need of services. Priority will be established by consideration of the following criteria:

A. availability of other community services to meet the individual’s needs;

B. ability of the case manager to provide services that meet the individual’s health and safety needs; and

C. the immediacy of the need for intervention in light of the risk of institutionalization, deterioration, or death.

2 - 6 Plan of Care

The comprehensive care plan is the fundamental tool by which the State ensures the health and safety of recipients. The case management team, with input from the recipient and his or her representative, develops a plan of care which addresses the needs of the recipient, the services necessary to meet those needs, and the goals to be achieved.

A. Prior to the delivery of waiver services, there must be a completed plan of care in the case management record of each recipient.

B. The plan must describe, at a minimum, the type, amount, frequency, and duration of services to be furnished to the recipient. The care plan must include the following elements:

1. effective date;
2. name and address of recipient;
3. waiver case manager's name and Area Agency;
4. all waiver and non-waiver services needed by the recipient, regardless of the funding source, including case management;
5. documentation of recipient's choice of waiver services and waiver providers;
6. expected start date, amount, frequency, and duration of each service;
7. the type of provider who will furnish each service;
8. goals for each service, where appropriate; and
9. the signatures and the date(s) signed.

C. All plans of care must be signed and dated by the client or legal representative, the R.N. case manager, and the S.S.W. case manager within 14 calendar days of establishing the plan of care.

D. The case manager is responsible for ensuring the recipient receives the services identified in the plan of care.

2 - 7 Periodic Review of the Plan of Care

The plan of care must be reviewed periodically to determine the appropriateness and adequacy of the services, and to ensure that services furnished are consistent with the nature and severity of the recipient's disability.

A. The case management team is responsible for periodic review and update of the plan of care.

B. The case manager must conduct a formal review at least every three months with completion during the calendar month in which it is due. However, should the recipient experience a **significant change** in his or her health, the plan of care must be reviewed within 14 days of the change in health status; or if the recipient was in an acute care facility, within 14 days of his or her return to his or her place of residence.

1. A significant change is defined as a major change in the recipient's status that:

   - is not self-limiting;

   - impacts on more than one area of the recipient's health status; and

   - requires interdisciplinary review and/or revision of the plan of care.

   NOTE A condition is defined as self-limiting when the condition will normally resolve itself without intervention by waiver personnel. For example, normally a five percent weight loss would trigger a reassessment. However, if a client had the flu and experienced nausea and diarrhea for a week, a five percent weight loss may be an expected outcome. In this case, the case manager should monitor the recipient's status. If the recipient did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time that would be appropriate to monitor a recipient depends on the situation and severity of symptoms experienced by the client. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

2. A reassessment as a result of a significant change is required if decline or improvement is consistently noted in two or more areas of decline, or two or more areas of improvement.

C. The case manager must evaluate the goals indicated in the plan of care and assure that services ordered are appropriate. If necessary, the periodic review of the plan of care should indicate additional services to be provided and any changes in goals. Any such revision must be discussed with the recipient. The case manager must initiate the necessary notification of changes to service providers directly affected by the change.

D. All plan-of-care reviews must be signed and dated by the client or legal representative, the R.N. case manager, and the S.S.W. case manager within 14 days after completion of the review.

E. If there are no changes, it must be so indicated on the plan-of-care review.

2 - 8 Reevaluations of Level of Care

A. The case management team must complete the level-of-care evaluation at least annually within 12 months after entry into the waiver for the elderly or within 12 months of the most current assessment with completion during the calendar month in which it is due. The purpose of the reassessment is to document the recipient's level of care and to assure that waiver services continue to be a feasible alternative to institutionalization for the recipient and adequately meet the recipient's needs.

B. Reevaluations must be conducted as follows:

1. A comprehensive reassessment of the recipient by the case management team must be conducted in order to determine if the recipient continues to be eligible for the home and community-based waiver for the elderly.

2. The case management team is responsible for recertifying the need for continued service. The initial level-of-care determination must be reevaluated along with the social and behavioral history to determine if services are still necessary and appropriate. Changes since the initial evaluation mus t be documented; or if no change has occurred, there must be documentation why an update is not needed.

3. Recipients found ineligible for continued waiver services will receive notice and hearing rights in accordance with Chapter 2-10, *Fair Hearings.*

2 - 9 Termination of Home and Community-Based Waiver Services

A. The waiver case manager will provide a written notice to a recipient and his or her legal representative upon termination of home and community-based waiver services. The recipient and legal representative will also receive a notice of the right to appeal such decisions.

B. Waiver services may be terminated for the following reasons:

1. death of the recipient;

2. whereabouts of the recipient unknown;

3. recipient no longer meets the level-of-care requirements;

4. recipient moved out of the state of Utah;

5. recipient voluntarily withdrew from the waiver program;

6. waiver services are no longer a feasible option, (recipient cannot be safely maintained in the community);

7. recipient is no longer eligible for Medicaid.

C. For recipients who are determined ineligible for waiver services, the Department allows 10 days from the date of the determination for the case manager to complete an orderly termination of services and transition to other programs, if necessary.

2 - 10 Fair Hearings

A. The Utah Department of Health will provide an opportunity for a fair hearing to applicants or recipients who are:

1. denied eligibility for waiver services;

2. determined eligible for waiver services but not offered the choice of waiver services as an alternative to NF services; or

3. denied access to an available service or provider of their choice.

B. Agency Responsibility for Fair Hearings

1. It is the policy and preference of the Division of Health Care Financing to resolve disputes at the lowest level through open discussion and negotiation between the Division, applicants/recipients, and all other interested parties;

2. The Department will provide an opportunity for a fair hearing to waiver recipients who are:

a. denied eligibility for waiver services;

b. not offered the choice of institutional (NF) services or waiver services;

c.. denied the waiver services or provider(s) of their choice.

C. The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, Division of Health Care Financing, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/UMAP Recipients, Applicants, and Providers in Section 1, Chapter 6 - 14, Administrative Review/Fair Hearing.

3 HOME AND COMMUNITY-BASED WAIVER SERVICES

Waiver recipients are eligible to receive regular Medicaid State Plan benefits (i.e., hospital, physician, pharmacy, medical equipment, and supplies). In addition, **when necessary to prevent institutionalization and delivered pursuant to a written, signed plan of care, the waiver services listed below are available to recipients:**

- Case Management
- Adult Day Care
- Respite Care
- Homemaker Services
- Supportive Maintenance
- Nonmedical Transportation
- Emergency Response System
- Home-Delivered Meals
- Companion Services

3 - 1 Case Management

Case management services assist recipients to gain access to and coordinate needed assessment, medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Medicaid reimbursement for case management is dictated by the nature of the activity and the purpose for which the activity was performed. Time spent by a waiver case manager performing covered activities will be reimbursed on a 15-minute basis.

A. BILLABLE CASE MANAGEMENT ACTIVITIES

When delivered by a qualified individual and billed in reasonable amounts (given the documented needs and condition of the particular recipient), the following activities and services are covered by Medicaid under case management:

1. assessing and documenting the recipient's need for community resources and services, including time spent developing the recipient's social history and initiating, coordinating and overseeing the process of evaluating the recipient's level of care;

2. developing, documenting, implementing and coordinating the recipient's plan of care to ensure he or she gains access to needed services; updating and modifying the plan of care as necessary and required;

3. linking the recipient with needed community resources including assisting the recipient to establish and maintain eligibility for entitlements (**other than Medicaid);**

4. coordinating the delivery of services to the recipient by encouraging the use of cost-effective medical care, and discouraging overutilization of costly and unnecessary services;

5. monitoring the provision of services included in the recipient's plan of care to ensure the continued availability and quality of delivered services;

6. Instructing the recipient or caretaker, as appropriate, in independently obtaining access to needed services for the recipient; and

7. assessing the recipient's progress periodically and reassessing his or her continued need and eligibility for waiver services;

8. assisting recipient to gain access to legal services in conjunction with a Medicaid hearing.

Limitations:

1. The waiver case manager will bill Medicaid for the above activities **only if:**

   a. The activities are delineated in the recipient's plan of care; and

   b. The time spent in the activity involved a face-to-face encounter, telephone or written communication with the client, family, or legal representative, caretaker, service provider, or other individual directly involved in providing or assuring the recipient obtained a service documented in the plan of care.

2. Case management reimbursement may be available for the time spent by a waiver case manager coordinating and conducting an assessment of a **noninstitutionalized** applicant's waiver eligibility.

   a. However, reimbursement is limited to time spent by the case management team:

      (1) conducting, coordinating, and fully documenting an assessment which meets the definition in Section 2 - 2, *Assessment*; and

      (2) only in the **30-day** period immediately prior to the applicant's first day of admission to the waiver.

   b. **No other waiver services provided during this period are billable to Medicaid. Further, if the applicant is found ineligible or if the applicant is found eligible but for any reason is not admitted to the waiver by the end of the 30-day period (e.g., is placed on a waiting list or chooses NF services), the time spent conducting the assessment is <u>not</u> billable as a case management service.**

B. NONBILLABLE ACTIVITIES

In accordance with federal Medicaid guidelines, the following are **not** considered case management services and should **not** be billed to Medicaid as such:

1. documenting case management services (with the exception of time spent documenting initial and periodic level-of-care assessments, plans of care, and quarterly review summaries);

2. teaching, tutoring, training, instructing or educating the recipient or others (except insofar as the activity is specifically designed to assist the recipient or legal representative, or caretaker to independently obtain needed services for the recipient). For example, instructing his or her family members on nutrition, budgeting, cooking, or other skills development;

3. directly assisting with activities of daily living or instrumental activities of daily living. For example, assisting with budgeting or paying bills, cooking, shopping, laundry, apartment hunting, moving residences, or acting as a protective payee;

4. performing routine services, including courier services. For example, time spent running errands or picking up and delivering foodstamps or entitlement checks;.

5. traveling to the recipient's home or other location where a covered case management activity will occur, nor time spent transporting a recipient or a recipient's family member;

6. providing services for or on behalf of other family members which do not directly assist the recipient to gain access to needed services;

7. recruitment and outreach activities in which the agency or waiver case manager attempts to contact potential recipients or service;

8. time spent assisting recipient to gather evidence for a Medicaid hearing or participating in a hearing as a witness.

C. BILLABLE ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

In accordance with federal Medicaid guidelines, the following activities are considered **administrative** case management services and should be billed to the Division of Aging and Adult Services:

1. time spent writing up, mailing to Medicaid, and documenting prior approvals;

2. time spent performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the individual to establish and maintain Medicaid eligibility;

3. discharge planning services provided to an NF recipient in the 30-day period immediately prior to his or her first day of admission to the waiver;

4. time spent by case manager assessing a noninstitutionalized applicant's waiver eligibility during the 30-day period immediately prior to admission to the waiver if the applicant is found ineligible or chooses NF services.

5. time spent gathering evidence and participating in a Medicaid hearing at the request of DHCF because of adverse action against a recipient.

3 - 2 Adult Day Care

Adult day care means the continuous care and supervision of frail elderly adults provided in an adult day care center licensed by the Department of Human Services. Care may include socialization, recreation, and cultural activities that stimulate the individual and help him or her maintain optimal functioning.

Limitations:

A. Adult day care services are provided for three or more adults for at least four but less than 24 hours a day.

B. Medication management, physical, occupational, and speech therapy are not available as part of adult day care services.

C. Transportation between the recipient's place of residence and the adult day care center must be provided as a component of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. (An exception will be made when the adult day care center cannot provide transportation. In such case, the transportation portion will be deducted from the adult day care rate.)

3 - 3 Respite Care

Respite care is service given to recipients unable to care for themselves, provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care may be provided only in the following locations:

A. the recipient's home or place of residence;

B. a Medicaid-certified nursing facility;

C. a state-licensed assisted living facility or residential care facility;

D. a state-licensed swing-bed hospital.

E. a state-licensed adult day care center.

Medicaid requires written prior authorization for respite care by a homemaker or home health aide.

3 - 4 Homemaker Services

Homemaker services are general household services provided by a trained homemaker when the individual who usually performs these services is temporarily absent or unable to manage the household. General household services may include meal preparation and routine household maintenance.

Limitations:

Prior authorization is required for homemaker services.

3 - 5 Supportive Maintenance Services

Supportive maintenance services are long-term support services provided by a home health aide to elderly recipients who have continuing health problems.

Limitations:

A. Supportive maintenance services are limited to homebound recipients.

B. Supportive maintenance services may be provided only in the recipient's home or place of residence.

C. Supportive maintenance services may be provided only by home health aides who have been certified by the State Office of Education.

D. Prior authorization is required for supportive maintenance services.

3 - 6 Nonmedical Transportation

Nonmedical transportation is a service to enable recipients to gain access to non-Medicaid community services specified in the plan of care.

Limitations:

Nonmedical transportation will be reimbursed only if the service is not available from family, friends, church, volunteers, or public transportation.

3 - 7 Emergency Response System

Emergency response system is an electronic device which enables recipients to secure help in the event of an emergency.

Limitations:

Services of an emergency response system are limited to high-risk waiver recipients who live alone, or who are alone for significant parts of the day, and who would otherwise require extensive routine supervision.
(High-risk recipient means an individual who because of physical incapacity needs ongoing supervision or a means of accessing assistance if left alone.)

3 - 8 Home-Delivered Meals

Home-delivered meals are meals provided to waiver recipients in their place of residence as a supplement to Meals-on-Wheels.

Limitations:

A. Meals may be delivered only to homebound recipients who are unable to prepare their own meals or who have no caretaker to prepare their meals.

B. Home-delivered meals may be used only as a supplement (such as meals provided on weekends) to "meals-on-wheels" provided through the Area Agency on Aging. Reimbursement is not available for a full nutritional intake.

C. If a waiting list exists for meals funded through the Older Americans Act, a daily meal (not to exceed two meals per day) may be provided through the waiver.

3 - 9 Companion Services

Companion services are nonmedical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the plan of care, and is not merely diversional in nature and does not entail hands-on medical care.

4 RECORD KEEPING

A. All individuals and agencies providing Medicaid-reimbursed home and community-based waiver services must develop and maintain sufficient written documentation to support the services billed.

B. Sufficient written documentation includes the following:

1. the name of the recipient who received the service(s);
2. the specific reimbursable service provided pursuant to the recipient's plan of care;
3. the date the service was rendered;
4. the nature, extent and units of service, including when services began and ended;
5. name of provider agency and person providing service;
6. periodic updates describing the recipient's response to the service (e.g., progress or the lack of progress);
7. The record must be kept on file and made available as requested for state or federal audit or review purposes.

5 PRIOR AUTHORIZATION

Prior authorization means that degree of Medicaid agency approval for payment of services required to be obtained by a licensed provider. Such approval must be obtained prior to services being provided.

Requirements

A. The case manager must submit a completed "Request for Prior Approval" form, plan of care, "date service is to begin", and any supporting documentation for any homemaker and supportive maintenance services designated in the plan of care. (A copy of the plan of care need not be sent in with recertifications, but should be sent in annually. If there are changes in services, a copy of the quarterly review form should be sent with the new prior authorization.)

B. Prior authorization requests and attached documentation will be reviewed by Community-Based Services Unit staff. If approval is indicated, approval will be given for up to 90 days unless the care needs indicate that less time is required.

C. A written request must be received and approved before any payment can be made. Before submitting a claim, the home health agency must have received a copy of the "Request for Prior Approval" form back from the Community-Based Services Unit with the prior approval number. The case manager will also receive a copy of the approved prior approval form from the Community-Based Services Unit. This copy should be filed in the recipient record.

D. For enrolled recipients, prior authorization forms will be required every 90 days upon the required certification date.

E. Prior authorization does not guarantee a reimbursement or the eligibility of the recipient. The recipient must be Medicaid-eligible on the date the service is rendered.

F. When there is a need for more services than were approved in the original prior authorization request, the case manager may call or write the Community-Based Services Unit and request additional units of service. Justification for the increase must be provided.

Mail Prior Authorization Requests to:

Prior Authorization/Aging Waiver
Community-Based Services Unit
Division of Health Care Financing
Box 142835
Salt Lake City UT 84114-2835

Or use FAX Number: (801) 538-6099

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6 TIME LIMIT TO SUBMIT CLAIMS

Effective July 1, 1999 Medicaid providers billing under a Provider Number for the 1915(c) Home and Community-Based Services Waiver for Individuals 65 and Older (the Aging Waiver) must submit a claim for payment no later than 90 days from the actual date of service in order for the claim to be eligible for payment.

THIS CHANGE ONLY AFFECTS CLAIMS FOR THOSE SPECIFIC SERVICES COVERED BY THE HOME AND COMMUNITY-BASED WAIVER PROGRAM AND BILLED UNDER THE PROVIDER NUMBER ASSIGNED FOR THE AGING WAIVER. Claims for State Plan services provided to Medicaid recipients who also participate in the Aging Waiver may be submitted up to 12 months from the date of actual service.

The allowable time frame within which a claim may be filed is being reduced from 12 months to 90 days in order to effectively manage the Aging Waiver's established annual budget allocation, to assure funds available during each fiscal year are properly allocated to eligible Medicaid recipients, and to provide an increased level of quality oversight for the care plan implementation process.

7 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-Based Services Waiver for Individuals 65 and Over.

Y0460 **Home-Delivered Meals (unit - one meal)** - are meals provided to homebound individuals in their place of residence.
Limits: May be provided only as a supplement to other meals.

Y0461 **Nonmedical Transportation (round trip)** - is transportation to enable recipients to gain access to community services other than Medicaid medical care.
Limits: Family members will not be reimbursed for the provision of transportation services.

Y0462 **Emergency Response System (unit - one month)** - is an electronic device which enables high-risk individuals to secure help in the event of an emergency.
Limits: May be provided only to those individuals who live alone or who are alone for significant parts of the day.

Y0463 **Adult Day Care (unit - one day)** - is care and supervision provided in a licensed setting to provide socialization and recreational activities for frail elderly adults.

Y0464 **Case Management [Wasatch Front (unit - 15-minute increments)]** - is a service for locating, coordinating, and monitoring necessary and appropriate services for individuals.

Y0465 **Respite Care [In-Home (unit - one hour)]** - is a service provided on a short-term basis to individuals in their own homes in the relief of regular caregivers.
Limits: Respite care may only be provided in a recipient's home or place of residence.

Y0466 **Homemaker Services (unit - one hour)** - are household services provided by a trained homemaker when the caregiver is absent or unable to manage the household.
Limits: Requires prior authorization.

Y0467 **Supportive Maintenance (unit - one hour)** - is home health care provided by a home health aide to frail elderly individuals in their place of residence.
Limits: May be provided only to homebound individuals.
Requires prior authorization.

Y0468 **Nonmedical Transportation (one way)**
Limits: Same as Y0461.

Y0469 **Emergency Response System (installation/removal)**
Limits: Same as Y0462.

Y0521 **Companion Service (unit - one hour)** - is nonmedical care, supervision, and socialization provided to a functionally-impaired adult
Limits: May not include hands-on care.

Y0522 **Respite Care [out-of-home (unit - one day)]** - is a service provided on a short-term basis to individuals in an institutional or residential facility.
Limits: Only 14 days allowed for each stay.

Y0523 **Case Management (all areas outside of Wasatch Front)**

Y0524 **Assessment (areas along the Wasatch Front)**
An evaluation to determine if recipients qualify for the waiver and to assess individual's needs and condition for care planning purposes.
Limits: Recipient must be Medicaid and waiver eligible. Must be performed within 14 days after referral.

Y0525 **Assessment (areas outside of Wasatch Front)**
Limits: Same as Y0524.

Y0526 **Respite Care -- Homemaker**
Service is provided on a short-term basis by a homemaker to individuals in their own homes in relief of regular caregivers.
Requires written prior authorization.
Limit: unit - one hour

Y0527 **Respite Care -- Home Health Aide**
Service is provided on a short-term basis by a home health aide to individuals in their own homes in relief of regular caregivers
Requires written prior authorization.
Limit: unit - one hour